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UNICEF/WHO JOINT COMMITTEE ON HEALTH POLICY

Report of the twenty-ninth session held at the headquarters of the World Health Organization

Geneva, 1-2 February 1993

UNICEF-WHO JOINT COMMITTEE ON HEALTH POLICY JCHP29/93.18
Twenty-ninth session
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REPORT OF THE UNICEF/WHO JOINT COMMITTEE ON HEALTH POLICY ON ITS TWENTY-NINTH SESSION

WHO headquarters, Geneva
1-2 February 1993

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I. INTRODUCTION

1. Dr Y. Kawaguchi, Director, Planning, Coordination and Cooperation, WHO, opened the session and welcomed participants. He called for nominations for Chairman and two Rapporteurs.

2. Mr F. Ward, Chairman of the UNICEF Executive Board, was unanimously elected Chairman. Mr M. Al-Sakaff (Yemen), member of the UNICEF Executive Board, and Dr Meropi Violaki-Paraskeva (Greece), member of the WHO Executive Board, were elected Rapporteurs.

3. The Chairman recalled that in 1992 the UNICEF/WHO Joint Committee on Health Policy (JCHP) had met in special session primarily to discuss urgent follow-up to the World Summit for Children. The more extensive agenda for the current session reflected the need to review the development of health policy over the past two years, to continue to monitor progress toward the goals set at the World Summit for Children, to consider closely related activities, particularly in respect of health infrastructure, and to receive progress reports on collaboration between UNICEF and WHO in various other areas of critical importance to the health of women and children. The purpose of the meeting was to inform, exchange views and, where possible, to make recommendations to the Executive Boards of UNICEF and WHO. Both organizations were facing human and financial constraints; it might therefore not be possible to do everything immediately. They would have to make some hard choices and set priorities. They would also have to decide on activities that the two organizations could implement together and those for which one of them should take the sole or leading responsibility.

4. The proposed agenda[1] was adopted and is attached as Annex 1. The list of participants is given in Annex 2.

II. SUMMARY OF STATEMENTS BY THE DIRECTOR-GENERAL OF WHO AND THE EXECUTIVE DIRECTOR OF UNICEF

5. Dr Hiroshi Nakajima, Director-General of WHO, observed that JCHP was meeting at a very important juncture in the history of the United Nations. Everywhere there were calls for reform, restructuring and revitalization. Organizations and bodies were being asked to ensure that there was an integrated approach to development throughout the United Nations system.

6. In many parts of the world women and children, in particular, were threatened by hunger and deprivation caused by famine, natural disasters or civil strife. Efforts to promote development were overshadowed by the need to provide emergency and humanitarian assistance. Thus, UNICEF and WHO faced enormous challenges in their efforts to promote the health status of women and children.

7. In the changing world of the 1990s, health demanded new partnerships, which implied a new social and international covenant, a sharing of resources and responsibilities at many different levels in order to tackle mutually agreed priorities, including the level at which JCHP operated.

8. Its efforts were a concrete response to the current world social and economic situation and the needs of women and children everywhere. Studies carried out in different parts of the world by WHO's Special Programme for Research and Training in Tropical Diseases showed that, because of their social and economic status, women remained at a considerable disadvantage with respect to health care. The repercussions on children could be considerable. Neither should the human rights implications of current disparities in health status be neglected. The fight against sexual and other forms of discrimination was of central concern. Pregnant women were particularly susceptible to infectious diseases, as well as to anaemia. Tropical diseases, such as leprosy and river blindness, caused people to drop out from family activities and school, and reduced marriage opportunities. Women were more affected than men because of their weaker status, and ultimately children suffered the consequences. Much work remained to be done in those areas.

9. The main purpose of the current session of JCHP was to recommend to the Executive Boards of UNICEF and WHO collaborative action to support countries in meeting the goals of the World Summit for

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[1] Document JCHP29/93.1.

Children. It was time to help to prepare countries for carrying out, in 1995, a mid-term review of progress in implementing the Plan of Action for achieving those goals. JCHP should review the policies adopted in the past two years by the Health Assembly and the decisions taken by the UNICEF Executive Board.

10. Happily there had been some notable achievements, and others could be expected. Together UNICEF and WHO had cooperated with countries in reaching 80% immunization coverage among children worldwide. Dracunculiasis would be eradicated by the end of 1995, and it was expected that poliomyelitis would be eradicated by the year 2000. The two organizations had also secured the commitment of the infant food industry to end free or low-cost supplies of infant formula to maternity wards and hospitals in all developing countries. There was, however, an acute problem caused by the rising price of vaccines in the face of rapidly increasing demand. He and the Executive Director of UNICEF would continue to negotiate with industry, but much more political commitment was required and resources had to be mobilized.

11. Three important events in 1992 had been the adoption by the Organization of African Unity of a resolution to fight AIDS in Africa; the adoption, at the Ministerial Conference on Malaria, of the World Declaration on the Control of Malaria; and the adoption, at the International Conference on Nutrition, of the World Declaration and Plan of Action for Nutrition. The essential pragmatic follow-up would require collaboration between UNICEF and WHO.

12. The first priority of WHO was its cooperation with countries in the implementation of health-for-all strategies, especially with countries in greatest need. One of WHO's most steadfast partners was UNICEF, but the road was rocky and conditions were sometimes unpredictable. Collaboration and coordination required determination, mutual respect and understanding, and a clear vision of what was to be achieved and how to achieve it, including agreement on the respective roles of the partners. In the next two years progress towards the attainment of the goals set by countries would have to be carefully monitored. WHO and UNICEF would have to help countries to ensure that the infrastructure for health was in place. WHO would continue to make its considerable experience and expertise available in joint or collaborative efforts, and in its search for effective programme delivery.

13. Mr J. Grant, Executive Director of UNICEF, noted that progress in health matters had been greater than in education or economics. For instance, child mortality had been halved in WHO's Eastern Mediterranean Region since 1980. Without the Expanded Programme on Immunization and the achievement of universal childhood immunization there would probably have been no World Summit for Children, the follow-up to which had been widely supported. The United Nations Conference on Environment and Development (UNCED) had adopted the goals of the Summit as essential components of Agenda 21. Furthermore, the Convention on the Rights of the Child had been ratified by 128 States in record time. Some 140 States had been preparing national plans of action. Several important regional meetings on national programmes of action had recognized that the goals set at the Summit could be realized, that national programmes of action should be refined in terms of relevance to budget processes and should also have their equivalents at the provincial and municipal levels, and that intermediate goals for 1995 should be set for at least several of the Summit goals, such as those for oral rehydration therapy, measles immunization and elimination of iodine deficiency.

14. Since the special session of JCHP in 1992, despite all the problems in the world, the momentum in achieving health goals had been clearly maintained. No cases of poliomyelitis had been reported in the Region of the Americas for 15 months, there was to be an end to the free distribution of infant formula and breast-milk substitutes, and elimination of iodine deficiency was being pursued.

15. Everyone was aware of the destructive emergencies that were occurring (more UNICEF staff members had lost their lives in the past year than in the past 10 years put together). The international community, recognizing the need to feed people in such conditions as prevailed in Somalia and in former Yugoslavia, had taken action in that connection. Considerable advances have been made with respect to the concept of health for all. For example, the United States of America, as part of its health-for-all strategy, had utilized the power of communication and mobilization to change behaviour and thereby to prevent disease and ill health.

16. Continued progress depended greatly on international cooperation. Target-setting by UNICEF and WHO could make a big difference. Success, especially in the case of Africa, depended on an increase in

resources. It had been recommended that 20% of official development assistance should be devoted to meeting priority human needs, and that special attention be given to addressing the problem of African debt.

III. REVIEW OF WHO HEALTH POLICIES AND UNICEF DECISIONS

17. The document under consideration[1] presented resolutions concerning the health of women and children adopted by the Forty-fourth and Forty-fifth World Health Assemblies in May 1991 and May 1992, and relevant decisions adopted by the UNICEF Executive Board in June 1992. The addendum to the document set out the text of those resolutions and decisions in full. JCHP had found it useful to carry out such a review at regular intervals. In 1991 and 1992 the Health Assembly had adopted 21 resolutions containing policies and principles having a direct bearing on the health and well-being of women and children. In 1992 the UNICEF Executive Board had adopted eight such decisions. The common themes running through the resolutions included reinforcing primary health care; intensifying research of all types; supporting training, intersectoral cooperation and integrated approaches, focusing on those most in need; and mobilizing resources to augment national efforts. JCHP was requested to decide which issues should be emphasized when referring them to the respective Executive Boards.

Women and children's health

18. JCHP emphasized the need to ensure that the policies indicated in resolutions WHA44.4, WHA44.7, WHA44.33, WHA45.5, WHA45.17, WHA45.34 and WHA45.35 were implemented. The attention of the UNICEF Executive Board was drawn to the fact that resolution WHA45.33 had been adopted before the International Conference on Nutrition; the challenge now was to implement the Plan of Action adopted at that Conference, one of the priorities being to overcome micronutrient deficiencies for which global goals had been set within the framework of the World Summit for Children. Collaborative action was urgently needed to develop strategies for supporting national programmes in that regard. In particular, it was suggested that the UNICEF Executive Board support the endeavour to prevent iron deficiency anaemia during pregnancy. Resolutions WHA44.42 and WHA45.25 on "women, health and development" outlined ways in which women's health and well-being could be improved at all levels. A serious problem was that diverse socioeconomic factors resulted in differences in status or treatment that were harmful to women's health; it was suggested that the UNICEF Executive Board should take special note of that point and lend its support to the action being taken to implement the resolutions in question. The need for a strategy and plan of action for the health of women of all ages was noted.

Health and the environment

19. The Committee stressed the increasing importance attached to matters affecting health and the environment, especially since UNCED. Agenda 21 adopted at the Conference outlined the basis for a global strategy. Diarrhoeal and many other diseases were causing substantial child mortality as a result of failure to manage the environment. The world's population was growing and the environmental situation in large cities was getting out of control. Although UNICEF and WHO had collaborated in many ways, for instance in the hygiene education project, much remained to be done if goals were to be met.

Technical cooperation

20. As far as technical cooperation in countries facing specific difficulties was concerned, both organizations attached great importance to the provision of health and medical assistance to Somalia. Condolences were expressed concerning the young UNICEF staff member who had recently died there.

Supporting services

21. It was noted that over half the population in developing countries still lacked regular access to the most needed essential drugs and that the WHO programme on essential drugs was fundamental to UNICEF/WHO collaborative efforts to ensure the availability of a selected number of safe and effective drugs and vaccines of

[1] Document JCHP29/93.2.

acceptable quality at the lowest possible cost. It was therefore considered important that the UNICEF Executive Board should take note of resolution WHA45.27.

UNICEF Executive Board decisions on health

22. It was pointed out that UNICEF spent some 65% of its resources in the health field. Relevant Health Assembly resolutions were always noted by the UNICEF Executive Board and always formed the guidelines for UNICEF's related operations. In 1991 UNICEF had spent US$ 246 million on health, US$ 45 million on nutrition, and US$ 93 million on water and sanitation. In 1992 the figures had been US$ 290 million, US$ 52 million and US$ 114 million, respectively. Funds were spent mainly on the provision of supplies and materials, on system- and capacity-building, and on training and social mobilization. Copies were distributed[1] of the UNICEF Executive Board's 10 decisions on health of women and children adopted in 1991.

23. The UNICEF Executive Board had selected Africa as the region of the highest priority. Other priority areas include the least-developed countries in general and the poorest population sectors. The importance of following up the World Summit for Children was also stressed. Further areas for attention included acute respiratory infections, the Children's Vaccine Initiative, cholera, sustainability and national capacity-building, as well as the Bamako Initiative and AIDS, in respect of which a social focus was to be maintained. The UNICEF Executive Board had also reviewed collaboration with UNFPA in family planning, and in its decision on breast-feeding it had specified that it would support, in collaboration with WHO and other agencies, efforts to end free and low-cost supplies of infant formula and breast-milk substitutes in maternity wards and hospitals in developing countries by December 1992. In its relations with WHO, UNICEF always worked on the basis of "comparative advantage".

24. Appreciation was expressed concerning the large amounts that UNICEF was devoting to health, and the hope that it would continue. The focus on Africa was also welcome and gave scope for many collaborative activities in relation to the drought in southern Africa and to WHO's programmes of support to people in the greatest need. Sustainability, integration and national capacity-building, being essential to primary health care, also provided opportunities for thoughtful cooperation. UNICEF was to be particularly congratulated on the action taken with regard to support for family planning within the maternal and child health programme. Note had been taken of UNICEF's decision to facilitate information-sharing among countries and to support the training of health workers. The results of the UNICEF Executive Board's continuing discussions on UNICEF's family planning policy were awaited with interest. WHO was heartened by the increased attention that UNICEF was paying to the HIV pandemic as it affected women and children, particularly the emphasis placed on emotional needs and the avoidance of discrimination. In any event, optimum use should be made of available resources.

25. The Committee noted the complementarity between the Health Assembly resolutions and the UNICEF Executive Board decisions. Nevertheless, certain priorities would have to be established, and formulation of a sustainable health framework incorporating all the programmes involved could be considered.

26. **Recommendations.** (i) The Executive Boards of UNICEF and WHO should reinforce complementary action to strengthen primary health care programmes, to intensify research, to support training, capacity-building, intersectoral cooperation and integrated approaches, to focus on those most in need, and to mobilize resources to augment national efforts in those areas. Every effort should be made to follow up the goals of the World Summit for Children, giving special attention also to HIV/AIDS in children.

(ii) It is important that the governing body of each organization should be made aware of resolutions and decisions adopted by the other, so that priorities can be established and action taken to fulfil broad policy goals.

(iii) Resource constraints should be acknowledged and priorities set accordingly, and optimum use should be made of available resources.

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[1] See list in Annex 3.

IV. WORLD SUMMIT FOR CHILDREN

Follow-up action

27. The document under discussion[1] identified intermediate goals that were technically feasible, indicating that appropriate technology was available, and that goals might be attained at low cost. Such goals might help both to provide a focus for the mid-decade review called for by the World Summit for Children, and to increase confidence in the attainability of the longer term targets.

28. The Executive Director, UNICEF, stressed the leadership in following up the World Summit that had emerged in the health field. Regional consultations on national programmes of action had brought out the desirability of establishing additional goals where technical capabilities existed and where financing did not appear to present insuperable difficulties. Although differences existed between regions, all had accepted the commitments entered into at the Summit. The pursuit of selected intermediate goals should not preclude progress in areas where such goals had not been fixed; it should, moreover, encourage rather than inhibit an integrated approach. The Consensus of Dakar, adopted by the International Conference on Assistance to African Children in November 1992, was brought to the attention of the Committee as an excellent illustration of imaginative regional follow-up.

29. The Committee noted that several recent regional gatherings had agreed upon intermediate goals, some of which differed from those in the UNICEF/WHO paper to varying degrees. The importance of integration could not be overemphasized: the attempt to reach several goals together enhanced their attainment individually. Sustainability was also important. Lastly, additional areas of serious and increasing concern, for example, HIV/AIDS, substance abuse, and the matter of healthy life-styles might also be the subject of intermediate goals, each of which would assume a different significance according to the circumstances of the country concerned.

30. Nevertheless, the overall vision of securing the highest attainable level of health for every person should not be obscured, and the use of joint UNICEF/WHO indicators would help to monitor progress towards that objective. (See next item.)

31. The importance was stressed of an essential health framework within which objectives and activities might be fitted together in a coherent pattern. The fixing of targets had a stimulating effect, and the last of the proposed intermediate goals, the interruption of guinea-worm transmission in villages, should lead to its elimination in entire countries.

32. Particular attention was drawn to the importance of human resources; to the potential of the primary health care framework for the pursuit of the goals set by the Summit; and to the need for partnership and - more especially - intersectoral collaboration in dynamic health care activities designed to transform those goals into realities. Whether developing or industrialized, and irrespective of its situation, circumstances or health status, each country should see each day as an occasion for meeting a new challenge and moving ahead.

33. Monitoring was again stressed as an essential means of obtaining rapid feedback and as an instrument for adjusting strategies. The importance was highlighted of complementarity between UNICEF and WHO - based on "comparative advantage" - in the implementation of an integrated strategy.

34. The Committee welcomed and saw the need for intermediate goals in order to achieve the longer term targets of the Summit. It noted, however, that individual regions and countries would have to set their own priorities and timetables within those parameters. Country priorities would be most accurately reflected in the national programmes of action, already completed or currently in the process of completion in some 140 countries. All countries that had not yet embarked on such programmes should be encouraged to do so, and to complete them as soon as possible.

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[1] Document JCHP29/93.3.

35. The Committee endorsed the intermediate goals.[1] It noted the importance of investment in capacity-building within countries, together with the motivation and training that would permit the implementation of programmes on an integrated basis - particularly within the framework of primary health care - and their monitoring.

Progress made

Health indicators and monitoring methods

36. During the introduction of the background paper[2] it was pointed out that, although the design of a common set of health indicators and monitoring methods to help strengthen national programme management was still in progress, the table of recommended indicators contained in Annex B of the document had been updated and was in the process of finalization. WHO's Global Programme on AIDS had proposed the inclusion of additional HIV/AIDS-related indicators. (See also paragraph 83.)

37. Every attempt was being made to finalize as rapidly as possible a limited number of indicators that would be useful, practical and easy to apply, so as not to impose an excessive burden on national administrations. UNICEF and WHO would promote the monitoring process, and planned to issue a joint statement on monitoring the health of women and children, the text of which would be produced by the two secretariats once the indicators were finalized. Monitoring was seen as a critical area of complementarity between UNICEF and WHO.

38. Attention was drawn to current weaknesses in monitoring at country level, especially in terms of consistency and regularity. Since information structures and systems were weak or nonexistent in many countries, the indicators should be easy to apply, and designed in such a way that maximum use might be made of existing information.

39. The Committee took note of the successful work done by the two secretariats so far on indicators, and urged them to complete their task if possible by 1 March 1993, including one or two HIV/AIDS-related indicators in the recommended list. It further noted the need to ensure that indicators and monitoring methods were practical and simple, reflecting positive health whenever possible.

Maternal health and newborn care

40. The joint background paper[3] presented a basic package for maternal and newborn care. The unacceptably high mortality rate that still accompanied pregnancy and delivery in many parts of the world must continue to receive priority, all the more so because the remedial actions needed had been clearly identified, skills were known and resources were obtainable. There was an inseparable link between the health of mothers and infants, even before the latter were born; quality care was needed during pregnancy. The fact that birth laid the foundations for healthy childhood and adult life underscored the importance of proper, well-supervised delivery and neonatal care - which did not call for sophisticated technologies or skills. The accelerated global implementation of maternal and newborn interventions for better health should be promoted urgently within child survival strategies. Maternal health and safe motherhood were the other side of the coin of child survival and development: newborn health was obviously a bridge between maternal health and infant and child health; yet the simultaneous improvement of maternal and newborn health still remained to be implemented. The simple, feasible, practical and adaptable set of family-, community- and health centre-based interventions, designated by WHO as "the mother and baby package", was designed to remedy that shortcoming, in association with the upgrading of midwifery skills and, as appropriate, within the framework of the "baby-friendly" hospital initiative.

41. The Committee noted that possible action could involve: first, jointly launching the mother and baby package, fostering its incorporation into international policies and programmes within primary health care as

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[1] See Annex 4.

[2] Document JCHP29/93.4.

[3] Document JCHP29/93.5.

part of the district health system, and encouraging national programmes to establish a focal point for the programme; second, updating and revising the joint UNICEF/WHO statement on maternal and newborn care in collaboration with other organizations and professional groups; third, continuing to support WHO's established research and development processes for the organization of maternal health services, the identification, adaptation and evaluation of technologies, the definition of procedures and the establishment of norms; and fourth, jointly promoting the upgrading of midwifery skills as the critical link between safe motherhood and newborn care.

42. The Committee noted UNICEF's concern at the scale of maternal and neonatal mortality and its particular attachment to the principle of clean delivery. The financial implications for UNICEF of the package developed by WHO had been roughly costed, and had been found extremely high. UNICEF therefore favoured a more selective approach, with concentration on priorities and special attention to feasible, low-cost interventions. It was essential to acknowledge the importance of the area for the attention of both organizations and to endorse the broad scope of the undertaking described by WHO; details of further UNICEF/WHO collaboration could be worked out on the basis of the advantages of each organization.

43. The link between maternal health and newborn health was well accepted. JCHP commended the "baby-friendly" hospital initiative, with the comment that the hospital should also be "mother-friendly", ensuring not only clean delivery and breast-feeding, but also good referral links with the district services responsible for care during pregnancy and after delivery. The connection between maternal health and the health of the newborn was underscored. The Committee pointed out that although the Declaration and Plan of Action adopted by the World Summit for Children set no goals in the specific domain of newborn health, the essential elements of maternal and newborn care had been identified by WHO, and a joint UNICEF/UNFPA/WHO statement had resolved the policy debate on the roles of traditional birth attendants in maternal and child health. Safe motherhood was a subject of concern to many bodies of the United Nations system and nongovernmental organizations anxious to stimulate and support country-level action. However, the absence of specific guidelines, norms and standards had led to recourse to *ad hoc* and sometimes inappropriate activities, and occasionally to the design of programmes with only tenuous links to the health sector. Attention was also drawn to the importance of training for traditional birth attendants.

44. The Committee agreed that joint activities should be practicable, realistic and simple to implement, and noted that many of the actions mentioned in the package were already under way as part of various programmes of the two organizations.

45. **Recommendations.** (i) Noting that, in general, sophisticated technology was not required for maternal health and newborn care, but that adequate training and basic support in the form of equipment were called for, JCHP recommends:

- strengthening the collaboration between UNICEF and WHO, together with UNDP and UNFPA, in order to accelerate research and development and to provide more effective support to national programmes;

- updating and revising the joint UNICEF/WHO statement on maternal and newborn care in collaboration with other organizations of the United Nations system and professional groups;

- fostering reliance on, and increased support to, WHO's established research and development processes for the identification and evaluation of technologies, the definition of procedures and the establishment of norms, drawing upon country experiences of UNICEF, national programmes and other organizations; and

- jointly initiating the upgrading of midwifery as the critical link between safe motherhood and newborn care and a factor in the elimination of neonatal tetanus.

(ii) Recognizing the importance of maternal health and newborn care, its links with other concerns, notably safe motherhood, and its impact on the elimination of neonatal tetanus, JCHP endorses the broad outline of the basic package for maternal and newborn care, taking into consideration suggestions and concerns expressed during the general discussion. It recommends that UNICEF and WHO should explore ways of improving

delivery at an affordable cost, recognizing the considerable work already being done by UNICEF, WHO, the World Bank and other organizations active in the area.

Vaccine needs

46. The background document containing an **overview of vaccine needs** and outlining a strategy for **meeting vaccine needs for the Expanded Programme on Immunization (EPI) in the 1990s**[1] was introduced with the comment that the goals of the World Summit for Children related to immunization and disease control are the priorities of EPI. Vaccine demand had grown in response to increased target populations, more ambitious immunization coverage goals and new disease eradication, elimination and reduction targets; vaccine prices had also risen steeply. In addition, EPI resources needed to be increased to ensure that new and improved vaccines could be made available to countries in greatest need. In response, UNICEF and WHO had developed a four-part strategic plan to ensure vaccine supply, which focused on increasing vaccine production or shared vaccine production in developing countries, helping developing countries to finance procurement of vaccine themselves through the Vaccine Independence Initiative, increasing the funding for vaccines, and working with manufacturers and suppliers of vaccines to keep prices stable. An approach (summarized in the tables in Annex I of document JCHP29/93.6/7) had been outlined to rationalizing country and donor support for the plan. By the end of 1993 it was hoped that at least 10 countries would have participated in the Vaccine Independence Initiative and at least 10 countries would have been visited by teams to assess vaccine supply and quality control. It was encouraging that the WHO Regional Committee for Africa had adopted a resolution to promote self-sufficiency in vaccines. If countries started taking over part of the financial burden of vaccine supply by meeting some costs in local currencies, immunization would become more sustainable and countries would have an incentive to use vaccines more efficiently. In negotiations with manufacturers and suppliers to minimize costs, one reason given for higher prices had been the short contracts offered by organizations of the United Nations system. A detailed forecasting exercise covering the rest of the decade had thus been carried out by UNICEF and WHO with a view to introducing longer contracts.

47. **The Children's Vaccine Initiative** (CVI) provided a strategic framework for mobilizing support to deal with the currently acute problems of vaccine availability and to promote development of a new generation of children's vaccines.[2] It also provided the international effort needed to apply technologically feasible techniques in the development of new and improved vaccines. Short-term goals in that area were to develop a poliomyelitis vaccine thermostable at 45°C in order to reduce dependence on the cold chain; to develop a single-dose tetanus toxoid in order to increase coverage among women of child-bearing age; and to produce a measles vaccine for very young children (less than nine months of age) for areas of high measles mortality and morbidity. A longer term strategy was to develop combination vaccines, for example, use of diphtheria, pertussis and tetanus vaccine as an immunization vehicle to which other vaccines could be added to meet local needs. Industry was already doing some work in that area. In addition, two task forces were visiting countries in order to assess local vaccine production and quality control. Generous donor support and collaboration was forthcoming for investment in order to make countries self-sufficient in those areas.

48. Although the drive towards vaccine independence was welcome, the Committee expressed some concern that countries in need should continue to receive support for vaccine procurement. Countries required time to adjust to vaccine independence. There was, nevertheless, a need to encourage countries to devote part of their health budgets to vaccine procurement. The independence initiative also helped countries to buy good-quality vaccines at costs lower than those negotiated on a bilateral basis. The Committee learned that CVI had expected to receive US$ 6.5 million from donors, but that pledges and funds in hand to date amounted to US$ 3.5 million; a downward revision of the budget might thus be required.

49. The Committee agreed that vaccines were among the most cost-effective means of improving health and ought to be given high priority in national budgets. It noted with concern the increasing price of vaccines used in EPI; the lack of sufficient resources to cope with the increasing demand for EPI vaccines resulting from broader target populations, new goals for immunization coverage and disease control, and the introduction of new vaccines; the possibility that locally produced vaccines might not always meet WHO quality requirements

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[1] Document JCHP29/93.6/7.

[2] Document JCHP29/93.8.

or that it might not be known if they did; and the reluctance of some governments to incorporate vaccine costs into government budgets.

50. **Recommendations.** (i) JCHP endorses the action proposed to overcome constraints, namely,

- support to countries that have the capacity to produce vaccines so that they become self-sufficient;
- through the Vaccine Independence Initiative, procurement of vaccines on behalf of governments with either convertible or local currencies;
- continued negotiation with vaccine suppliers so that they maintain provision of vaccines at affordable prices; and
- approaches to the donor community so that it contributes greater resources for the procurement of vaccines for EPI. This action should be given priority.

(ii) Stressing the importance of the Children's Vaccine Initiative and regretting that its progress has been somewhat slower than initially hoped, JCHP recommends that UNICEF and WHO should give greater attention to publicizing the programme and seeking increased external support for its efforts. Research on the development of new vaccines should also be stimulated.

Control of diarrhoeal diseases, including cholera, and acute respiratory infections

51. In introducing the background document,[1] it was pointed out that although diarrhoeal diseases and acute respiratory infections were common causes of disease and death, being responsible for two-thirds of all deaths among children under five years in developing countries, they were not highly visible and attracted little attention, especially from the world media. There was thus little drive to improve the situation, although most deaths were preventable by means readily available. Without attention to diarrhoeal diseases and acute respiratory infection the goals for mortality reduction set by the World Summit for Children would be unattainable. Cooperation between UNICEF and WHO at global level was excellent and was being built up at country level. A common strategy and indicators had been drawn up, and large-scale implementation was in view. However, ensuring the supply of antibiotics for management of acute respiratory infection required further attention. In the total picture of diarrhoeal disease mortality, cholera was relatively insignificant, but it had a high profile, and it was hoped to use the attention that the recent epidemic had provoked to increase support for diarrhoeal disease control, water supply and sanitation, and food safety. Continued advocacy for financial support was needed to meet the midterm goals and the goals for the year 2000 for both acute respiratory infections and diarrhoeal diseases, particularly the latter, subject to donor fatigue. UNICEF and WHO were building up an integrated approach to management of the sick child with regard to diarrhoeal diseases, acute respiratory infections, malaria, malnutrition and a number of other related conditions. The challenge was to design fresh, effective approaches to an old problem - organization of services at national level that reached into every home. Management capabilities had to be increased and ways sought to implement programmes at lower cost. Efforts had to be made to combat the irrational use of drugs and to ensure conformity of approach by all medical practitioners.

52. The Committee emphasized the need to concentrate on the control of diarrhoeal diseases if the goals of the Summit were to be achieved. It agreed that the public interest generated by the cholera epidemic should be used to draw attention to the needs of other diarrhoeal diseases. Since effective means of managing diarrhoeal diseases existed, efforts should be made to promote them and to discourage individuals and families from using ineffective methods. Attention should be paid to training in the management of acute respiratory infections. Greater efforts should be made to increase resources for the control of diarrhoeal diseases and acute respiratory infections and to encourage communities to join in the effort to reduce morbidity and mortality from such diseases. Attention to food hygiene was also important; cooperation with the WHO food safety programme in providing guidelines for making food safe in the home was appreciated. Water supply and sanitation also had considerable impact on diarrhoeal disease control; it was noted that the WHO

[1] Document JCHP29/93.9.

community water supply programme was closely involved and was also giving high priority to hygiene education in that area. Collaboration between UNICEF and WHO on those issues was excellent.

53. The Committee endorsed the action and goals set out in sections 4 and 5 of the background document, and the conclusion in paragraph 6.1 that the global goals for reducing childhood deaths by the year 2000 were achievable if governments were committed to implementing national control programmes, and if these programmes were backed by appropriate technical and financial support from national and external sources. The targets may not be appropriate to all countries, but, being global, a failure to meet the target in one country could be offset by achievements in another. However, if most country programmes remain at their present level or improve only slowly, the global targets will not be achieved.

54. **Recommendations.** (i) Noting with concern the large number of deaths still attributable to diarrhoeal diseases and acute respiratory diseases, JCHP recommends that the Executive Boards of UNICEF and WHO should urge governments to mobilize financial, technical, political and communication resources to provide the technically available means for reducing that mortality.

(ii) JCHP commends the active cooperation between UNICEF and WHO and among WHO programmes in combating diarrhoeal diseases and acute respiratory infections and urges that it should continue.

(iii) JCHP recommends that UNICEF and WHO should make every effort to define with countries the mechanisms for achieving their national targets, and to ensure that resources will be made available and a greater effort undertaken to implement national programmes. UNICEF and WHO should continue to work closely at country level in the planning and evaluation of control activities, and to coordinate their technical and financial inputs. This collaboration should also be coordinated with bilateral agencies and nongovernmental organizations.

V. DISTRICT HEALTH SYSTEMS

Action for supporting countries in the management of their district health systems

55. In introducing the joint background paper,[1] it was pointed out that district health systems (comprehensive structures encompassing far more than the traditional district management team and implanted in urban as well as rural areas) were by no means the sole tool for health development, and that imbalances which required correction might well exist between districts in a given country. Nevertheless, the district health system offered a unique mechanism for the integrated delivery of programmes and for the utilization of recognized entry points via priority programmes of primary health care - through the eradication of poliomyelitis, for example - a matter recently commended by WHO's Executive Board. Moreover, all the priority programmes reviewed by the Committee at its present session could be and, indeed, were being delivered through district health systems, sometimes in an innovative and invigorating fashion. The tasks to be carried out by the various components of those systems needed to be refined, and supplies and broad-ranging support and encouragement provided. Districts must also enjoy flexibility in the planning and utilization of their resources, which had implications for the functioning of donor agencies. More particularly, district health managers, who should not be bypassed by national and outside agencies, must be able to count on flexible funding. The strengthening of local mechanisms was the only way of ensuring the sustainability of action.

56. It was proposed that UNICEF/WHO action include support for operational research that would generate practical experience in district health system development and problem-solving; and for dissemination of the findings of such research. The two organizations should, perhaps above all, encourage countries to pool their experiences and learn from one another.

57. The Committee noted that the district traditionally consisted of the administrative interface between national and local government. On the basis of its experience, UNICEF believed that any programmatic approach should comprise two lines of action: popular empowerment with knowledge and skills for self-care, in the broadest sense of the term; and enhancement of health centres and first-referral hospitals as the major source of care that people could not provide for themselves.

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[1] Document JCHP29/93.10.

58. Operationally, UNICEF preferred to use its practical interventions leading to the enhancement of capabilities, motivation and task-setting within the framework of programmes it supports, thus giving a purpose to the infrastructure being built. The opportunities offered by the Bamako Initiative were most illustrative in that connection, since it built structures through shared financing between government, donors and the community.

59. The understanding, implementation and experience of decentralized activity in WHO's African, European and South-East Asia regions were the subject of statements, all of which explicitly or implicitly endorsed the district health system concept. The district health system approach in Africa was largely based on local administrative structures inherited from the colonial period. Those administrative units continued to be useful for health system development in WHO's African Region, where there were some 4000 districts. A clear distinction was made between strategic, technical and operational management: the principal locus for the latter was the district. Moreover, it had been clear since Alma-Ata that there could be no other locus than the district for the implementation of primary health care. Criteria had been worked out for determining the actual operational status of districts, so that action could be taken to correct shortcomings or deficiencies and more especially to create or strengthen the necessary management structures. A set of health indicators had been worked out that could be applied at the grass-roots level by ordinary citizens as well as health workers. Considerable attention was being paid to the promotion of public health training, and to the development of documentation services tailored to community needs. The Bamako Initiative, and more especially the element of participatory financing, had been found to be one of the best catalysts for effective district management leading to social control, by the community, of its own health care institutions. Lastly, it had been possible under the Bamako Initiative to set up a special health fund, with districts as its members, so that revenues generated in local currencies might be converted into the hard currency required to ensure a continued supply of essential drugs when donated stocks were exhausted.

60. The Committee noted that, to a varying extent in different countries, according to the amount of political will involved, South-East Asia had accumulated a great deal of experience, even before Alma-Ata, of cooperation between government and the community; health infrastructures were constantly being strengthened, with special emphasis on the training and motivation of community health workers and the regular upgrading and extension of their skills and responsibilities within the overall health-for-all context. It was essential for the community to be able to organize and monitor its own primary health care efforts, on the basis of its own selected priorities, in a context of district-to-district and even village-to-village cooperation, emulation and mutual support.

61. In WHO's highly-urbanized European Region, recent large-scale political developments had brought to the fore health issues that were the subject of an integrated approach, often with an environmental dimension. The intersectoral Healthy Cities project, involving more than 400 cities, east and west, was an example of intervention at the local level, and was helping to promote improved city health policies, public health infrastructures and community participation. Experience had shown that modest first-step initiatives could have a snowball effect; more favoured cities in the west had demonstrated their willingness to extend support to their disadvantaged neighbours in the east, especially in the domain of competence building. It had also been shown that specific programmes, on tobacco, alcohol abuse or HIV/AIDS, for example, could be fed into more general projects built on the basic policy of health promotion in a variety of different social settings, where those directly concerned established the priorities.

62. The district offered a very cost-effective grass-roots mechanism for improving the health of countries, at a level where investment, for example in the creation of management information and monitoring systems, but above all in building up capability, was likely to produce good results. There must also be genuine political will with regard to decentralization and the empowerment of the community with regard to both the management and the efficient utilization of the health system. Vertical integration must accompany the horizontal integration that was stressed in the background paper.

63. The Committee noted the broad interpretation given to the term "district", and the fact that district health systems could be both rural and urban. The significance of the district as the level where priority programmes could serve as entry points for comprehensive primary health care could not be overemphasized. Practical modalities in that connection could be investigated, the ultimate objective being integrated health delivery in districts, with decentralization and full assumption of managerial responsibility at that level for financial and other aspects of such delivery. Donors might be invited to review their somewhat rigorous

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policies and practices in the financing of health care activities, so as to allow for a measure of flexibility in the allocation of resources. Institutional networking should be fostered; and emulation could be a spur to performance.

64. For UNICEF, it appeared necessary to reduce the number of proposed actions - although all were important - and to view the undertakings on the basis of the advantages of each organization. Within its limited resources, which it wished to put to optimal use, UNICEF was inclined to exploit windows of opportunity opened by its own experience. These included action related to the Bamako Initiative or similar initiatives outside Africa; the training of health workers as a means of building up capability; the provision of supplies such as vaccines and cold chain equipment; assistance in the implementation of nutrition strategies; health education and the promotion of individual participation within the community; problem diagnosis; and advocacy and social mobilization. UNICEF was also in a position to act effectively with what might be called its "non-traditional" partners.

65. It was, however, pointed out that the district health system is essentially concerned with improving coordination and integration of activities for maximum efficiency. This was the context in which the areas for action by countries, as well as UNICEF and WHO, were recommended in the document.

Bamako Initiative: progress in participatory financing of health services

66. The Committee noted the major recommendations of the UNICEF background paper.[1] The first recommendation was that the "strategy of 'revitalizing health services' as defined by the 'features' of community financing, community participation and national orientation; the 'aims' of improving quality and extending access; and the 'strategic elements' of managing and accountability; together with the eight Guiding Principles of the Bamako Initiative should be supported as an appropriate path towards the development of Primary Health Care. Piecemeal and unbalanced approaches which omitted some of those elements were inadequate". The second recommendation was that "UNICEF and other agencies should continue to support countries' efforts to implement the Bamako Initiative and the need for substantial investment in this process should be recognized". Not everything found in the evaluation on which the paper was based had been positive, because the Bamako Initiative dealt with key social issues such as financing and decision-making powers. The areas recommended for further study and action were mainly the quality of services, together with the rational use of drugs, affordability and the related issue of cost recovery, price mechanisms, experimentation with prepayments and local health insurance. The community's role in decision-making was also an area needing further attention from external organizations and governments. District health centres served as the operational entry point in each community. A basic health unit without essential drugs, without management or rationalized diagnostic and therapeutic guidelines and without a governing body could not be expected to provide households with the basic health services required.

67. In the past five years more than 20 countries in sub-Saharan Africa had experimented with the Initiative, ensuring a policy of decentralization. UNICEF estimated that over 2000 health units in more than 200 districts were now co-managed and co-financed and provided essential services to more than 20 million people. However, it was estimated that if progress continued at that pace, only 60% of African children would have access to basic low-cost technology by the year 2040. Thus the effort to strengthen basic health units through a partnership between donors, governments and communities needed to be accelerated. The Bamako Initiative constituted a genuine contribution to solving Africa's problem of financing the acquisition of available health technology, improving efficiency, and containing costs. UNICEF and WHO had worked together on the Bamako Initiative, but there was still room for further collaboration.

68. It was noted that the Bamako Initiative meant different things to different organizations. It had been launched in 1987 at a time when the drive to extend health services to slums and rural areas had appeared to be in jeopardy because of the financial crisis. Existing health services had also been endangered. The attempt to universalize immunization coverage and certain other services had raised a question of how the initial "big push" could be sustained and how vaccines and essential drugs could be funded, since governments lacked the necessary foreign exchange. Drugs were essential to a modern health system. At the same time WHO had been leading a drive to develop district health systems and decentralization. Partly because of shortage of

[1] Document JCHP29/93.11.

funds, local communities had begun to finance their own health programmes. As a result, the African countries concerned had recognized a need for the self-financing of good-quality, low-cost essential drugs at the district level. Similar initiatives had existed in other parts of the world. The availability of essential drugs was an indispensable component of the maternal and child health programme. People were prepared to pay for drugs if they were purchased at much lower cost through UNICEF and WHO. The payments made included an element to meet the cost of local management.

69. One of the difficulties encountered in expanding the Initiative has been the slow pace at which donors had accepted the concept of the Bamako Initiative and provided financing. Given the situation of the sub-Saharan countries, significant long-term external aid would be required to meet health system needs. Debt relief for those countries, in exchange for a commitment to restructure their economies to promote basic education and health, could be one option.

70. Since indiscriminate use of the term "Bamako Initiative" would lead to misunderstanding and confusion, further clarification would be required, particularly with regard to its relationship to district health systems and the essential drug programme. Essentially, it was a means to promote primary health care, not a substitute for it. WHO had kept to the original definition, although UNICEF appeared to have developed it further. Consequently, WHO needed to know precisely what it was going to support. Initially, the Initiative had emerged as a response to the drive of the two organizations to revitalize primary health care in Africa. After an initial international contribution of seed money, communities would fund their own facilities on a non-profit basis.

71. The evolution of the Bamako Initiative concept should be seen in a positive light, since it was not a project but a body of reforms. It was not just a question of drugs and money, but of community participation and control. The Initiative had been developed in response to the breakdown of the official system through lack of funds and accountability.

72. It was suggested that a one to two-day seminar could be held to help clarify the interaction between the Bamako Initiative, essential drugs and the district health system.

73. JCHP agreed upon the following conclusions:

(i) JCHP encouraged UNICEF and WHO to promote and support district health systems.

(ii) JCHP understood the Bamako Initiative to be a means of supporting a sustainable health care system through community participation, financing and management.

(iii) JCHP emphasized that:

- it was necessary to build up the capabilities not only of health workers but also of administrators and managers;
- funding for district health systems should not rely too extensively on sale of drugs but should include other sources, such as insurance;
- community involvement was essential.

VI. IMPLEMENTATION OF THE "BABY-FRIENDLY" HOSPITAL INITIATIVE

74. The Committee noted from the background documents[1] that developments in the past 18 months had been so rapid that the breast-feeding target was becoming a reality, and that one of the mechanisms for achieving it was the "baby-friendly" hospital initiative. A total of 757 hospitals had been, or were being, designated as "baby-friendly"; they were designated by national teams, using international criteria. The target for December 1992 was the ending of free or low-cost supplies of infant formulas or breast-milk substitutes in developing countries. In 122 countries that practice did not exist, or the governments had taken action to end

[1] Documents JCHP29/93.12 and JCHP29/93.12 Add.1.

it; in only eight developing countries had no such action yet been initiated.[1] The Committee further noted that progress had also been made in many industrialized countries, particularly in Europe.

75. Guidance from JCHP was sought on monitoring compliance with government actions. It was suggested that an institution along the lines of Amnesty International might be in order for that purpose. WHO's Legal Counsel questioned the appropriateness of such an approach, in light of the responsibility of national authorities. It was clear from Article 11(4) of the International Code of Marketing of Breast-milk Substitutes that responsibility for the monitoring of compliance lay with governments, which could act individually on their own territories or collectively through the Health Assembly. That remained the most suitable method of ensuring proper monitoring at the national level. Best results were obtained when national authorities and interested parties - manufacturers, consumers associations, professional groups, women's groups and nongovernmental organizations - worked together. Although the initiative to ban free or low-cost supplies was very important, it should not detract from the fundamental goal of implementing the Code in its entirety and of promoting breast-feeding.

76. It was agreed that monitoring was vital to ensure that the Code was being respected. Such monitoring had to be carried out at country level since conditions varied from country to country, and national personnel needed to be trained in monitoring methods. It was stressed that monitoring should not be a government function alone; nongovernmental organizations should make an important contribution. In WHO's European Region local nongovernmental organizations had been established to keep watch on such initiatives as the Healthy Cities project or health promotion in schools; such groups tended to expand successfully into national then international bodies. UNICEF and WHO were constitutionally obliged to respond to any request by a country for technical support and could cooperate with countries in monitoring compliance with the Code.

77. In explanation of the different deadlines recommended for developing and developed countries to end distribution of free or low-cost supplies of infant formula, it was stated that progress was such that actual cessation of supplies could be expected in most countries by mid-1993. However, the conformity date for industrialized countries had been set to coincide with the entry into effect of the European Community directive on infant formula scheduled for June 1994. Reports from UNICEF field offices indicated that distribution seemed to continue in some countries in violation of government actions and that global monitoring by an independent professional body would greatly assist in exposing such violations. The need for industry to cooperate fully was emphasized.

78. JCHP expressed its appreciation of achievements with respect to the "baby-friendly" hospital initiative and action taken - by governments, UNICEF and WHO - to end the distribution of free or low-cost supplies of infant formula by the end of December 1992 in developing countries. The cooperation of nongovernmental organizations was acknowledged.

79. **Recommendations.** (i) JCHP recommends that UNICEF and WHO should urge full compliance, by June 1993, with government action prohibiting distribution of free or low-cost supplies of infant formula, and that the target date of June 1994 should be set for ending distribution of free or low-cost supplies of infant formula in both developing and industrialized countries.

(ii) JCHP reiterates the importance of achieving the 1995 operational target of the Innocenti Declaration, namely that all maternity wards and hospitals would be "baby-friendly", in accordance with criteria based on the joint WHO/UNICEF statement on breast-feeding and the special role of maternity services. It further reiterates the importance of government action in achieving all targets of the Innocenti Declaration.

(iii) JCHP reaffirms the importance of UNICEF and WHO support for:

- preparation of action strategies for protecting, promoting and supporting breast-feeding, including global monitoring and evaluation strategies;

- analysis and survey of national situations and design of national goals and targets for action;

[1] See annex to document JCHP29/93.12 Add.1, pp. 4 and 5.

- planning, implementation, monitoring and evaluation of national breast-feeding policies; and

- specialized training and/or services.

VII. PROGRESS REPORTS ON COLLABORATIVE ACTIVITIES

Prevention and control of AIDS in women and children

80. In the introduction to the item, it was pointed out that HIV/AIDS was increasing most rapidly in developing countries, and especially among women and children. Heterosexual transmission was now recognized as the predominant mode of spread, and perinatal transmission was the principal means whereby children became infected, one-third of children born to HIV-infected mothers being HIV positive.

81. JCHP noted with satisfaction that the scope of UNICEF and WHO cooperation in HIV/AIDS was steadily expanding and commended the joint and/or complementary activities of the two organizations.[1] Regarding policy coordination, the Committee noted the continued efforts to clarify matters related to HIV transmission through breast-feeding, and the participation of both organizations in mechanisms to improve coordination of HIV/AIDS activities at global and country levels (namely, the Inter-Agency Advisory Group on AIDS and the Task Force on HIV/AIDS Coordination).

82. The Committee further noted the three main areas of programme coordination: young people; reproductive health care and prevention and treatment of sexually transmitted diseases; and family care and counselling. It recognized the need to set AIDS prevention efforts with young people in the broader context of health and development promotion, and to include reproductive and sex education within that framework. UNICEF and WHO were also working together to improve the early diagnosis and treatment of sexually transmitted diseases in the context of reproductive health. JCHP called upon the two organizations to continue and expand cooperation in the three main programme areas.

83. Concern was expressed about the impact of AIDS on the goals of the World Summit for Children. Two of those goals, namely, the reduction of infant and child mortality by one-third, and the reduction of malnutrition by one-half, might not be achieved in countries where there was a high prevalence of HIV or where such prevalence was expected. AIDS might also affect the goal of reducing low birth weight. JCHP suggested that UNICEF and WHO should include one or two indicators in the list of those being used to monitor progress in the achievement of the health goals endorsed by the World Summit.

84. JCHP, noting that the subject was closely connected with that of healthy life-styles for youth, concluded as follows:

(i) the pandemic was truly global in distribution, affecting all countries and not restricted to specific high-risk groups;

(ii) there was increasing need for policy and programme coordination among all international and nongovernmental organizations;

(iii) AIDS was a difficult area, particularly so because no cure existed; education and information were the primary tools available to promote behavioural change; in the process, optimal use should be made of existing health care and education systems; the challenges were to focus those efforts on young people, among whom HIV transmission was highest, and to reach the poorest, most vulnerable groups;

(iv) nongovernmental organizations and community-based groups had a key role to play in ensuring effective national responses to HIV/AIDS;

(v) both organizations were encouraged to continue the development and implementation of programmes to improve knowledge about, and to reduce the transmission of, HIV; the process should

[1] See document JCHP29/93.13.

be iterative in character, with an aim of "going to scale" i.e., expanding action as widely as possible where it will have the greatest impact;

(vi) the organizations should report on progress to their respective Boards and to the next JCHP meeting.

Healthy life-styles for youth

85. In introducing the background document,[1] it was noted that the behaviour of young people was being affected by rapid social changes which weakened both the family and support structures, and placed young people at great risk. However, it was not always necessary to change behaviour as young people often demonstrated responsible behaviour, which should be sustained. UNICEF and WHO had developed an initiative based on a positive approach to young people. A series of joint meetings had been held, also involving other organizations. The principal objectives of such collaboration were to promote an understanding of the fact that the economic and social development of countries depended on the health development of young people; to promote the health and development of young people; and to mobilize new sources of financing. Activities would be based on sound information, and the principles of effective intervention.

86. The Committee noted that two-thirds of HIV infections occurred in young people under 25; that many people began smoking before the age of 18; that many substance abusers had acquired the habit when young; and that parental behaviour needed to be better developed before childbirth. It also noted that the development of adult social behaviour began in youth, and recognized the importance of providing young people with better life skills. It stressed the need to mobilize many groups throughout society to support young people, including by reinforcement of value systems. The emphasis of the collaborative effort would be on work with both formal and informal youth organizations. A major conference on youth would be held in 1995.

87. **Recommendations.** (i) Praising the work done, JCHP recommends that UNICEF and WHO continue to work together, on the following actions:

- elaboration and dissemination of knowledge to support global, regional and national investments in the health and capabilities of young people, as an essential contribution to the economic and social development of countries and communities;

- design and adaptation of key interventions which contribute to the health and development of young people, including strategies for their implementation, and methodologies for monitoring and evaluation, making use of the existing education system and involving governments;

- identification and coordination of technical and other resources which would strengthen and develop national-level activities with existing partners, including health and social welfare, education, and youth-serving nongovernmental organizations; and

- mobilization of new partners, such as the media, the world of entertainment, industry (manufacturing, agricultural and the informal sectors), the criminal justice system and nongovernmental organizations, in order to increase their contribution to improving the health and development of young people.

(ii) Noting that the area where UNICEF and WHO could make the greatest contribution over the next 10 years would be in changing attitudes, JCHP recommends that the two organizations should discuss further the best means of bringing about change. The aim should be to increase their effectiveness in the four areas listed above by modifying their ways of thinking and by involving other partners.

[1] Document JCHP29/93.17.

Health education

Comprehensive health education in schools

88. The progress of health promotion and health education among school-age children was reviewed in the introduction to the background document.[1] Social mobilization was the key to such endeavours; children in a school setting were a cost-effective and successful target for introducing healthy life-styles to a whole community. Involvement of pupils, parents, teachers, communities and community leaders was essential for attaining programme goals. School health education was an avenue by which such efforts could be institutionalized and rapidly taken to scale. The school system and school health education provided a framework for such infrastructure and delivery mechanisms. UNICEF and WHO had worked together closely in producing appropriate guidelines which were being introduced in a number of countries. Further work was, however, needed to achieve a more integrated approach both inside and outside the school setting.

89. The Committee took note of a cooperative project being undertaken by the WHO Regional Office for Europe with the Council of Europe and the Commission of the European Communities to bring school health promotion on basic issues relevant to deprived communities to a number of countries in eastern and central Europe. Cooperation with UNICEF in that effort would be welcome.

Hygiene education with specific reference to community water supply and sanitation

90. In the introduction to the background document[2] it was pointed out that until recently water supply and sanitation projects had not included promotion of hygienic practices in the home and the community. UNICEF and WHO were now concentrating efforts and reinforcing action in that area, including considerable interprogramme cooperation within the two organizations. They were also in the process of developing a joint programme of hygiene education, emphasizing behavioural changes. The programme contained six areas of current and future activity: operational research, strategy development in countries, training, use of existing educational systems, preparation of mass media materials, and building up capability. A joint strategy for hygiene education in water supply and sanitation was in preparation and would be completed during 1993.

91. JCHP welcomed the components of hygiene education in water supply and sanitation projects already in place and applauded the success so far achieved by joint action by UNICEF and WHO. It endorsed the work plan at present in preparation and looked forward to continuing close collaboration in education, in particular at country level, and the promotion of specific goals and plans that the two organizations could develop together.

92. JCHP underlined the critical importance of health education in promoting and maintaining health. Emphasis was placed on developing an integrated and comprehensive educational approach that encouraged health-supportive behaviours and life-styles as a substantial contribution to reduction of the morbidity and mortality associated with, among others, diarrhoeal diseases, tobacco, alcohol and other substance abuse, unplanned pregnancies, sexually transmitted diseases including HIV/AIDS, accidents and violence. It was a difficult, but essential, task to ensure that the right tools should be designed to generate healthy behaviour. The Committee took note of Costa Rica's experience in developing an effective water supply and treatment system that it was hoped would cover 95% of the country's needs by 1995.

93. Attention was drawn by the Executive Director, UNICEF, to the address by the Director-General, WHO, to the XIII World Conference on Health Education (Houston, 28 August to 2 September 1988), and more particularly to the following extracts:

> "We must recognize that most of the world's major health problems and premature deaths are preventable through changes in human behaviour and at low cost. We have the know-how and technology but they have to be transformed into effective action at the community level. ... An apt slogan, 'AIDS - don't die from ignorance', can be applied to practically every other health problem. ...

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[1] Document JCHP29/93.15.

[2] Document JCHP29/93.16.

Society must make it possible for people to live healthy lives. A grand alliance of *people, policy-makers* and *health professionals* is necessary.

Health educators must use *all* the means of communication at their disposal. Only thus can they help to create a healthy social climate, ensure supportive policies, and influence attitudes and values. Only thus can they empower people with knowledge and the relevant health skills to improve their own health."

94. **Recommendations.** (i) Appreciating the progress already made jointly in promoting health education in schools, JCHP recommends that UNICEF and WHO should pursue action in that area, for example by:

- cooperating with countries to implement comprehensive school health education, taking into account the needs expressed by education and health officials in countries and at the regional consultations on comprehensive school education;

- identifying countries that have potential for implementing and strengthening comprehensive school health education with which they would collaborate, together with other international organizations;

- identifying operational issues on which they might collaborate, on a meaningful scale, in order to develop or strengthen comprehensive school health education policies and to determine the means to plan and implement collaborative and complementary actions for building up capability in school health education at country level.

(ii) JCHP further recommends that UNICEF and WHO should intensify their efforts in health information, education and communication through all possible sources, and seek innovative approaches and partnerships with, among others, the media; political, community and religious leaders; the entertainment industry; youth organizations and other nongovernmental organizations; and existing health and information systems. It emphasizes the importance of well-integrated age-appropriate health education for young and school-age children, adolescents, parents and the community at large.

Malaria control

95. The introduction to the background document[1] reiterated that the principal aim of malaria control was to reduce morbidity and mortality and to strengthen national capabilities to cope with the disease. It reviewed the close partnership between UNICEF and WHO in malaria control, which dated from the inception of the malaria eradication programme in 1956. Currently such cooperation focused on strengthening of local capabilities, management and early diagnosis of the disease, community education, and promotion of personal protection measures, in particular insecticide-impregnated bed nets.

96. It was suggested that in view of the magnitude of the malaria control task, efforts should concentrate on areas where *falciparum* malaria, the most lethal variety of the disease, was endemic in chloroquine-resistant forms. Successful action there would bring down the mortality figures considerably.

97. **Recommendation.** Welcoming the partnership between UNICEF and WHO in malaria control and endorsing the main points of the global strategy as set out in the background paper, JCHP recommends that the two organizations prepare detailed strategies based on their "comparative advantages".

VIII. DATE OF THE THIRTIETH SESSION

98. It was agreed that the thirtieth session of the UNICEF/WHO Joint Committee on Health Policy should take place in Geneva immediately after the ninety-fifth session of the WHO Executive Board in January 1995. Consultations would be held between the two secretariats on the possibility of holding a special session in January 1994.

[1] Document JCHP/93.14.

IX. CONCLUDING REMARKS

99. Dr Hiroshi Nakajima, Director-General of WHO, after thanking the Chairman for his efficient conduct of what had been a very fruitful meeting, stressed that continuing collaboration between UNICEF and WHO remained of crucial importance. He had been delighted to learn of the active discussion during the meeting of a whole range of major issues. The importance of cooperation between UNICEF and WHO was exemplified in the "baby-friendly" hospital initiative. He was glad to note JCHP's interest in, and commitment to, district health systems and the Bamako Initiative in relation to such systems. The health challenges faced by countries today were greater than ever, and UNICEF and WHO must continue to support them, especially those in greatest need.

100. Mr James Grant, Executive Director of UNICEF, endorsed Dr Nakajima's remarks. From UNICEF's point of view, the meeting had been both extremely important and highly productive. A revolution in attitudes towards children was taking place, and the cutting edge of that revolution had been recent successes in the health field. UNICEF and WHO had managed to work together synergistically; JCHP had been a most important mechanism in that process and, for example, a key instrument in reaching agreement on the goals for the World Summit for Children. There was now an increased sense of urgency in meeting those needs about which something could be done, as captured in JCHP's recommendations.

ANNEX 1

AGENDA

1. OPENING

   1.1 Statement by the Director-General of WHO and the Executive Director of UNICEF

   1.2 Election of Chairman and Rapporteurs

   1.3 Adoption of Agenda — JCHP29/93.1

2. REVIEW OF WHO HEALTH POLICIES AND UNICEF DECISIONS

   Selected resolutions adopted by the World Health Assembly and the WHO Executive Board in 1991 and 1992 and decisions adopted by the UNICEF Executive Board in the same years — JCHP29/93.2

3. WORLD SUMMIT FOR CHILDREN

   3.1 **Follow-up action**
   An overview of implementation of the Summit goals within the context of priorities for 1995 and 2000 — JCHP29/93.3

   3.2 **Progress made**
   Progress made in specific areas, including monitoring and evaluation, and in programmes which illustrate the action needed to assure impact by mid-decade

   3.2.1 Development of health indicators and monitoring methods for use in monitoring the goals of the World Summit for Children — JCHP29/93.4

   3.2.2 Maternal and newborn care — JCHP29/93.5

   3.2.3 Vaccine needs

   3.2.3.1 Overview of vaccine needs — JCHP29/93.6/7
   3.2.3.2 Meeting vaccine needs for the Expanded Programme on Immunization in the 1990s — JCHP29/93.6/7
   3.2.3.3 The Children's Vaccine Initiative — JCHP29/93.8

   3.2.4 Diarrhoeal and acute respiratory disease control including response to the cholera epidemic — JCHP29/93.9

4. DISTRICT HEALTH SYSTEMS

   4.1 Action for supporting countries in the management of their district health systems — JCHP29/93.10

   4.2 Bamako Initiative: progress in participatory financing of health services — JCHP29/93.11

5. IMPLEMENTATION OF THE "BABY-FRIENDLY" HOSPITAL INITIATIVE — JCHP29/93.12

Annex 1

6. PROGRESS REPORTS ON COLLABORATIVE ACTIVITIES

6.1 Prevention and control of AIDS in women and children: implementation of collaborative activities — JCHP29/93.13

6.2 Malaria control — JCHP29/93.14

6.3 Health education

6.3.1 Comprehensive health education in schools — JCHP29/93.15

6.3.2 Hygiene education with specific reference to community water supply and sanitation — JCHP29/93.16

6.4 Healthy life-styles for youth — JCHP29/93.17

7. OTHER MATTERS

8. CLOSURE

ANNEX 2

LIST OF PARTICIPANTS

WHO Executive Board members

Dr K. A. M. Al-Jaber
Director of Preventive Medicine
Ministry of Public Health
Qatar

Dr Qhing Qhing Dlamini
Deputy Director of Health Services
Ministry of Health
Swaziland

Dr Li Shi-chuo
Deputy Director
Department of Foreign Affairs
Ministry of Public Health
China

Dr Tin U
Adviser
Ministry of Health
Myanmar

Dr Meropi Violaki-Paraskeva (**Rapporteur**)
Honorary Director-General of Health
Greece

Dr B. Wint
Chief Medical Officer
Ministry of Health
Jamaica

UNICEF Executive Board members

Mr Frederick Ward (**Chairman**)
Director General, North Africa and Middle-East Division (BFM)
Africa and Middle-East Branch
Canadian International Development Agency,
Chairman, UNICEF Executive Board

Dr Alvaro Aguilar-Peralta
Clinica Aguilar Peralta
Avenida 4, Calles 22-24
No 2234 San José
Costa Rica

Dr Mohamed Al-Sakaff (**Rapporteur**)
Director-General of the Technical Cooperation Department
Ministry of Public Health
Sana'a
Yemen

Miss Samba Luisa Mbimbi
Attaché, Permanent Mission of Angola to the United Nations
New York

Mr Edmond Nzapa-Yeke
Counsellor for Economic Affairs
Permanent Mission of the Central African Republic to the United Nations
New York

UNICEF

Mr James P. Grant, Under-Secretary-General, Executive Director
Dr Richard Jolly, Deputy Executive Director (Programmes)
Dr Nyi Nyi, Special Assistant to the Executive Director
Mr K. Gautam, Director, Programme Division
Mr S. Basta, Director, UNICEF Geneva
Dr R. Atapattu, Senior Adviser, PHC and Coordinator, Health Cluster
Ms B. Carlson, Senior Adviser, Statistics and Monitoring
Mr G. Ghosh, Chief, Water and Sanitation Cluster
Dr T. Hill, Senior Health Adviser and Chief, Child Survival Unit
Mrs H. Kittani, Assistant Secretary, UNICEF Executive Board
Ms M. Kyenkya-Isabyre, Adviser, Infant Feeding
Ms F. Moneti, Senior Adviser, AIDS Programme
Dr A. Paganini, Manager, BIMU
Dr J. Rohde, Special Health Adviser to the Executive Director
Dr M. Sharma, Senior Adviser, CDD/ARI
Dr J. Sherry, Senior Adviser, Health Promotion Unit, Programme Division

Annex 2

Ms L. Vogel, Adviser
Dr C. Voumard, Senior Adviser, Health, Geneva

WHO

Dr Hiroshi Nakajima, Director-General
Mr D. Aitken, Assistant Director-General (ADG)
Mr R. J. Anderson, Chief, Office of External Coordination (ECO)
Dr F. S. Antezana, Director, Action Programme on Essential Drugs (DAP)
Dr J. E. Asvall, Director, Regional Office for Europe (EURO)
Mr M. Barton, Programme Manager, Office of Information (INF)
Dr M. Belsey, Programme Manager, Maternal and Child Health (MCH)
Dr D. Benbouzid, Nutrition (NUT)
Dr D. Blake, Deputy Director, Global Programme on AIDS (GPA)
Dr G. A. Clugston, Chief, Nutrition (NUT)
Dr K. Cravero, Global Programme on AIDS (GPA)
Mr A. L. Creese, Responsible Officer, National Health Systems and Policies (NHP)
Dr P. de Raadt, Director, Control of Tropical Diseases (CTD)
Mr H. S. Dhillon, Director, Division of Health Education (HED)
Mr H. W. Emblad, Director, Programme on Substance Abuse (PSA)
Dr H. Friedman, Chief, Adolescent Health (ADH)
Dr H. A. Gezairy, Regional Director for the Eastern Mediterranean (EMRO)
Dr E. H. Goon, Director, Division of Development of Human Resources for Health (HRH)
Dr A. Hammad, Special Adviser to the Director-General on Health and Development Policies (DGO)
Dr H. R. Hapsara, Director, Epidemiological Surveillance and Health Situation and Trend Assessment (HST)
Dr R. H. Henderson, Assistant Director-General (ADG)
Dr Hu Ching-Li, Assistant Director-General (ADG)
Dr J. P. Jardel, Assistant Director-General (ADG)
Dr M. Jancloes, Chief, Office of International Cooperation (ICO)
Dr B. Jazbi, Special Adviser to the Director-General (DGO)
Dr Y. Kawaguchi, Director, Planning, Coordination and Cooperation (PCO)
Dr R. Kim-Farley, Director, Expanded Programme on Immunization (EPI)
Dr S. Kingma, Liaison Officer GPA (AFRO)
Dr A. V. Kondrachine, Chief, Malaria Control (MAL)
Dr W. Kreisel, Director, Division of Environmental Health (EHE)
Dr A. G. Landi, Planning, Coordination and Cooperation (PCO)
Mr C. M. Lee, Principal External Relations Officer (WHO/UN)
Dr Maaza Bekele, Planning, Coordination and Cooperation (PCO) - **Secretary**
Dr L. J. Martinez, Associate Director, Division of Communicable Diseases (CDS)
Dr M. J. Mercier, Director, Promotion of Chemical Safety (Central Unit of the International Programme on Chemical Safety) (PCS)
Dr M. H. Merson, Director, Global Programme on AIDS (GPA)
Dr N. Napalkov, Assistant Director-General (ADG)
Dr D. K. Ray, Chief, Office of Governing Bodies and Protocol (GBP)
Dr J. Rochon, Director, Health Protection and Promotion (HPP)
Dr S. Sapirie, Chief, Monitoring, Evaluation and Projection Methodology (MEP)
Mr M. Subramanian, Chief, Global Health Situation Assessment and Projections (GSP)
Dr I. Tabibzadeh, Division of Strengthening of Health Services (SHS)
Dr E. Tarimo, Director, Division of Strengthening of Health Services (SHS)
Dr A. Tekle, Director, Division of Emergency Relief Operations (ERO)
Dr J. L. Tulloch, Director, Diarrhoeal and Acute Respiratory Disease Control (CDR)
Dr T. Türmen, Director, Division of Family Health (FHE)
Dr Muchtar R. Uton, Director, Health System Infrastructure (SEARO)
Dr D. B. Warner, Director, Community Water Supply and Sanitation (CWS)

ANNEX 3

UNICEF EXECUTIVE BOARD DECISIONS, 1991

1991/4	Action to assist the least developed countries
1991/5	The fight against cholera
1991/6	Reaching the poorest
1991/10	The role of UNICEF in World Summit follow-up
1991/11	The role of UNICEF in support of sustainable national health care systems
1991/13	Ensuring child survival, protection and development in Africa
1991/16	Children's Vaccine Initiative
1991/18	The Bamako Initiative
1991/22	The role of UNICEF in the promotion and support of breastfeeding
1991/23	The role of UNICEF in combating acquired immune deficiency syndrome

ANNEX 4

WORLD SUMMIT FOR CHILDREN

Intermediate goals for 1995

1. Eliminate neonatal tetanus through both immunization and clean delivery;

2. Reduce measles deaths by 95% and cases by 90%, through high coverage with immunization, and reaching those not yet reached;

3. Achieve poliomyelitis-free status in countries in the American, European and Western Pacific regions of WHO, as well as selected countries in other regions; comprising at least 60% of the world population;

4. Achieve at least 80% oral rehydration therapy use and continued feeding in selected countries, and 80% of the following in all countries: proper case management at home and health facility, or by health provider; access to oral rehydration salts and case management; and improving mothers' knowledge;

5. End distribution of free or low cost breast-milk substitutes in all maternity centres and hospitals in the developing countries by the end of 1992, and in all countries by June 1994;[1] achieve "baby-friendly hospital" status by all hospitals in 1995 in accordance with the "baby-friendly" hospital initiative;

6. Achieve full implementation of universal salt iodization in most of the countries where iodine deficiency disorders (IDD) are a public health problem; where full salt iodization is not possible in areas where IDD is a severe public health problem, supplementation with oral or injected iodized oil will be recommended as a temporary measure;

7. Achieve a significant increase in dietary intake of vitamin A in children from 6 months to 6 years of age, through food and/or fortified products, where diets are deficient in vitamin A. Where clinical vitamin A deficiency is a public health problem, vitamin A supplementation for preschool children every 4 to 6 months will be urged, as a time-bound short-term measure, until dietary intakes reach basal requirements;

8. Stop guinea-worm transmission in all affected villages.

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[1] The conformity date for industrialized countries has been set to coincide with the entry into effect of the European Community directive on infant formula scheduled for June 1994.